CABINET FOR HEALTH SERVICES
Commission for Children with Special Health Care Needs
Health and Development Division

911 KAR 2:200. Coverage and payment for Kentucky Early Intervention Program services.

RELATES TO: 20 USC 1471-1485, 34 CFR Part 303
STATUTORY AUTHORITY: KRS 194A.030(7), 194A.050, 200.650-676, 34 CFR 303.520-303.528, 20 USC 1473
NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Heath Services is directed by KRS 200.650 to 200.676 to administer funds appropriated to implement provisions, to enter into contracts with service providers, and to promulgate administrative regulations. This administrative regulation establishes the provisions relating to early intervention services for which payment shall be made on behalf of eligible recipients.

Section 1. Participation Requirements. An early intervention provider that requests to participate as an approved First Steps provider shall comply with the following:

(1) Submit to an annual review by the CCSHCN, or its agent, for compliance with 911 KAR 2:100 through 911 KAR 2:180 and this administrative regulation;
(2) Meet the qualifications for a professional or paraprofessional established in 911 KAR 2:150 or employ or contract with a professional or paraprofessional who meets the qualifications established in 911 KAR 2:150;
(3) Ensure that a professional or paraprofessional employed by the provider who provides a service in the First Steps Program shall attend a minimum of a one (1) day, not to exceed an eight (8) hour period, training on First Steps' philosophy, practices, and procedures provided by First Steps representatives prior to providing First Steps services;
(4) Agree to provide First Steps services according to an individualized family service plan as required in 911 KAR 2:130;
(5) Agree to maintain and to submit as requested by the CCSHCN required information, records, and reports to insure compliance with 911 KAR 2:100 through 911 KAR 2:180 and this administrative regulation;
(6) Establish a contractual arrangement with the Cabinet for Health Services for the provision of First Steps services; and
(7) Agree to provide upon request information necessary for reimbursement for services by the Cabinet for Health Services in accordance with this administrative regulation, which shall include the tax identification number and usual and customary charges.

Section 2. Reimbursement. The CCSHCN shall reimburse a participating First Steps provider the lower of the actual billed charge for the service or the fixed upper limit established in this section for the service being provided.

(1) A charge submitted to the CCSHCN shall be the provider's usual and customary charge for the same service.
(2) The fixed upper limit for services shall be as follows:
    (a) Primary service coordination. Primary service coordination shall be provided by face-to-face contact or by telephone on behalf of a child, with a parent, family or person in custodial control of a child, a professional or other service provider, or other significant person in the family's life.
        1. In the office, the fee shall be sixty-one (61) dollars per hour of service.
        2. In the home or community site, the fee shall be eighty-three (83) dollars per hour of service.
    (b) Initial service coordination. Initial service coordination shall be provided by face-to-face contact, in accordance with 911 KAR 2:100, Section 1, or by telephone on behalf of a child, with a parent, family or person in custodial control of a child, a professional or other service provider, or other significant person.
        1. In the office, the fee shall be sixty-eight (68) dollars per hour of service.
        2. In the home or community site, the fee shall be ninety-one (91) dollars per hour of service.
    (c) Primary level evaluation. The developmental component of the primary level evaluation shall be provided by face-to-face contact with the child and parent as defined in 911 KAR 2:100. [~~:~~]
        1. In the office or center based site, the fee shall be $225 per service event.
        2. In the home or community site, the fee shall be $225 per service event.
    (d) Intensive clinic evaluation. The intensive level evaluation shall be provided by face-to-face contact with the child and parent as defined in 911 KAR 2:100.
        1. In the office or center-based site the fee shall be $1,100 per service event.
        2. In the community site the fee shall be $1,100 per service event.
    (e) Therapeutic intervention, service assessment and collateral services in accordance with Section 3(4), (6) and (7) of this administrative regulation:

1. For an audiologist:
    a. In the office or center based site, the fee for a:
        (i) Service assessment, collateral service or a therapeutic intervention other than co-treatment shall be sixty-three (63) dollars per hour of service.
        (ii) Co-treatment shall be thirty-two (32) dollars per hour of service.
    b. In the home or community site, the fee for a
        (i) Service assessment, collateral service or a therapeutic intervention other than co-treatment shall be eighty-nine (89) dollars per hour of service.
        (ii) Co-treatment shall be forty-five (45) dollars per hour of service.
2. For a family therapist:
    a. In the office or center based site, the fee for a:
        (i) Service assessment, collateral service or a therapeutic intervention other than co-treatment shall be sixty-three (63) dollars per hour of service.
        (ii) Co-treatment shall be thirty-two (32) dollars per hour of service.
    b. In the home or community site, the fee for a:
        (i) Service assessment, collateral service or a therapeutic intervention other than co-treatment shall be eighty-nine (89) dollars per hour of service.
        (ii) Co-treatment shall be forty-five (45) dollars per hour of service.
3. For a licensed psychologist or certified psychologist with autonomous functioning:
    a. In the office or center based site, the fee for a:
        (i) Service assessment, collateral service or a therapeutic intervention other than co-treatment shall be $139 per hour of service.
        (ii) Co-treatment shall be seventy (70) dollars per hour of service.
    b. In the home or community site, the fee for a:
        (i) Service assessment, collateral service or a therapeutic intervention other than co-treatment shall be $203 per hour of service.
        (ii) Co-treatment shall be $102 per hour of service.
4. For a certified psychological associate:
    a. In the office or center based site, the fee for a:
        (i) Collateral service or a therapeutic intervention other than co-treatment shall be $104 per hour of service.
        (ii) Co-treatment shall be fifty-two (52) dollars per hour of service.
    b. In the home or community site, the fee for a:
        (i) Collateral service or a therapeutic intervention other than co-treatment shall be $153 per hour of service.
        (ii) Co-treatment shall be seventy-seven (77) dollars per hour of service.
5. For a developmental interventionist:
    a. In the office or center based site, the fee for a:
        (i) Service assessment, collateral service or a therapeutic intervention other than co-treatment shall be sixty-one (61) dollars per hour of service.
        (ii) Co-treatment shall be thirty-one (31) dollars per hour of service.
    b. In the home or community site, the fee for a:
        (i) Service assessment, collateral service or a therapeutic intervention other than co-treatment shall be eighty-one (81) dollars per hour of service.
        (ii) Co-treatment shall be forty-one (41) dollars per hour of service.
6. For a developmental associate:
    a. In the office or center based site, the fee for a:
        (i) Collateral service or a therapeutic intervention other than co-treatment shall be forty-five (45) dollars per hour of service.
        (ii) Co-treatment shall be twenty-three (23) dollars per hour of service.
    b. In the home or community site, the fee for a:
        (i) Collateral service or a therapeutic intervention other than co-treatment shall be sixty-eight (68) dollars per hour of service.
        (ii) Co-treatment shall be thirty-four (34) dollars per hour of service.
7. For a registered nurse:
    a. In the office or center based site, the fee for a:
        (i) Service assessment, collateral service or a therapeutic intervention other than

co-treatment shall be sixty-three (63) dollars per hour of service.

(ii) Co-treatment shall be thirty-two (32) dollars per hour of service.

b. In the home or community site, the fee for a:

(i) Service assessment, collateral service or a therapeutic intervention other than co-treatment shall be eighty-nine (89) dollars per hour of service.

(ii) Co-treatment shall be forty-five (45) dollars per hour of service.

8. For a licensed practical nurse:

a. In the office or center based site, the fee for a:

(i) Collateral service or a therapeutic intervention other than co-treatment shall be twenty-four (24) dollars per hour of service.

(ii) Co-treatment shall be twelve (12) dollars per hour of service.

b. In the home or community site, the fee for a:

(i) Collateral service or a therapeutic intervention other than co-treatment shall be thirty-two (32) dollars per hour of service.

(ii) Co-treatment shall be sixteen (16) dollars per hour of service.

9. For a nutritionist:

a. In the office or center based site, the fee for a:

(i) Service assessment, collateral service or a therapeutic intervention other than co-treatment shall be sixty-three (63) dollars per hour of service.

(ii) Co-treatment shall be thirty-two (32) dollars per hour of service.

b. In the home or community site, the fee for a:

(i) Service assessment, collateral service or a therapeutic intervention other than co-treatment shall be eighty-nine (89) dollars per hour of service.

(ii) Co-treatment shall be forty-five (45) dollars per hour of service.

10. For a dietitian:

a. In the office or center based site, the fee for a:

(i) Service assessment, collateral service or a therapeutic intervention other than co-treatment shall be sixty-three (63) dollars per hour of service.

(ii) Co-treatment shall be thirty-two (32) dollars per hour of service.

b. In the home or community site, the fee for a:

(i) Service assessment, collateral service or a therapeutic intervention other than co-treatment shall be eighty-nine (89) dollars per hour of service.

(ii) Co-treatment shall be forty-five (45) dollars per hour of service.

11. For an occupational therapist:

a. In the office or center based site, the fee for a:

(i) Service assessment, collateral service or a therapeutic intervention other than co-treatment shall be sixty-three (63) dollars per hour of service.

(ii) Co-treatment shall be thirty-two (32) dollars per hour of service.

b. In the home or community site, the fee for a:

(i) Service assessment, collateral service or a therapeutic intervention other than co-treatment shall be eighty-nine (89) dollars per hour of service.

(ii) Co-treatment shall be forty-five (45) dollars per hour of service.

12. For an occupational therapist assistant:

a. In the office or center based site, the fee for a:

(i) Collateral service or a therapeutic intervention other than co-treatment shall be forty-six (46) dollars per hour of service.

(ii) Co-treatment shall be twenty-three (23) dollars per hour of service.

b. In the home or community site, the fee for a:

(i) Collateral service or a therapeutic intervention other than co-treatment shall be seventy (70) dollars per hour of service.

(ii) Co-treatment shall be thirty-five (35) dollars per hour of service.

13. For an orientation and mobility specialist:

a. In the office or center based site, the fee for a:

(i) Service assessment, collateral service or a therapeutic intervention other than co-treatment shall be sixty-one (61) dollars per hour of service.

(ii) Co-treatment shall be thirty-one (31) dollars per hour of service.

b. In the home or community site, the fee for a:

(i) Service assessment, collateral service or a therapeutic intervention other than co-treatment shall be eighty-one (81) dollars per hour of service.

(ii) Co-treatment shall be forty-one (41) dollars per hour of service.

14. For a physical therapist:

a. In the office or center based site, the fee for a:

(i) Service assessment, collateral service or a therapeutic intervention other than co-treatment shall be sixty-three (63) dollars per hour of service.

(ii) Co-treatment shall be thirty-two (32) dollars per hour of service.

b. In the home or community site, the fee for a:

(i) Service assessment, collateral service or a therapeutic intervention other than co-treatment shall be eighty-nine (89) dollars per hour of service.

(ii) Co-treatment shall be forty-five (45) dollars per hour of service.

15. For a physical therapist assistant:

a. In the office or center based site, the fee for a:

(i) Collateral service or a therapeutic intervention other than co-treatment shall be forty-six (46) dollars per hour of service.

(ii) Co-treatment shall be twenty-three (23) dollars per hour of service.

b. In the home or community site, the fee for a:

(i) Collateral service or a therapeutic intervention other than co-treatment shall be seventy (70) dollars per hour of service.

(ii) Co-treatment shall be thirty-five (35) dollars per hour of service.

16. For a speech therapist:

a. In the office or center based site, the fee for a:

(i) Service assessment, collateral service or a therapeutic intervention other than co-treatment shall be sixty-three (63) dollars per hour of service.

(ii) Co-treatment shall be thirty-two (32) dollars per hour of service.

b. In the home or community site, the fee for a:

(i) Service assessment, collateral service or a therapeutic intervention other than co-treatment shall be eighty-nine (89) dollars per hour of service.

(ii) Co-treatment shall be forty-five (45) dollars per hour of service.

17. For a speech therapist assistant:

a. In the office or center based site, the fee for a:

(i) Collateral service or a therapeutic intervention other than co-treatment shall be forty-six (46) dollars per hour of service.

(ii) Co-treatment shall be twenty-three (23) dollars per hour of service.

b. In the home or community site, the fee for a:

(i) Collateral service or a therapeutic intervention other than co-treatment shall be seventy (70) dollars per hour of direct contact service.

(ii) Co-treatment shall be thirty-five (35) dollars per hour of service.

18. For a social worker:

a. In the office or center based site, the fee for a:

(i) Service assessment, collateral service or a therapeutic intervention other than co-treatment shall be sixty-one (61) dollars per hour of service.

(ii) Co-treatment shall be thirty-one (31) dollars per hour of service.

b. In the home or community site, the fee for a:

(i) Service assessment, collateral service or a therapeutic intervention other than co-treatment shall be eighty-one (81) dollars per hour of service.

(ii) Co-treatment shall be forty-one (41) dollars per hour of service.

19. For a teacher of the deaf and hard of hearing:

a. In the office or center based site, the fee for a:

(i) Service assessment, collateral service or a therapeutic intervention other than co-treatment shall be sixty-one (61) dollars per hour of service.

(ii) Co-treatment shall be thirty-one (31) dollars per hour of service.

b. In the home or community site, the fee for a:

(i) Service assessment, collateral service or a therapeutic intervention other than co-treatment shall be eighty-one (81) dollars per hour of service.

(ii) Co-treatment shall be forty-one (41) dollars per hour of service.

20. For a teacher of the visually impaired:
a. In the office or center based site, the fee for a:
(i) Service assessment, collateral service or a therapeutic intervention other than co-treatment shall be sixty-one (61) dollars per hour of service.
(ii) Co-treatment shall be thirty-one (31) dollars per hour of service.
b. In the home or community site, the fee for a:
(i) Service assessment, collateral service or a therapeutic intervention other than co-treatment shall be eighty-one (81) dollars per hour of service.
(ii) Co-treatment shall be forty-one (41) dollars per hour of service.
21. For a physician providing a collateral service in the office or center based site, the fee shall be seventy-six (76) dollars per hour of service. A physician shall not receive reimbursement for therapeutic intervention.
22. For an assistive technologist specialist:
a. In the office or center based site, the fee for a:
(i) Service assessment, collateral service or a therapeutic intervention other than co-treatment shall be sixty-one (61) dollars per hour of service.
(ii) Co-treatment shall be thirty-one (31) dollars per hour of service.
b. In the home or community site, the fee for a:
(i) Service assessment, collateral service or a therapeutic intervention other than co-treatment shall be eighty-one (81) dollars per hour of service.
(ii) Co-treatment shall be forty-one (41) dollars per hour of service.

(g) Respite shall be seven (7) dollars and sixty (60) cents per hour.

(3) Except as specified in subsection (4) of this section, a payment for services listed in subsection (2) of this section shall be based on a unit of service in fifteen (15) minute increments. One hour of service shall be considered four (4) units.

(a) For therapeutic intervention, service assessment or collateral services, units shall be determined using the beginning and ending time for a service documented in staff notes in accordance with 911 KAR 2:130, Section 2(9)(g)1. That shall be computed as follows:
1. Fifteen (15) to twenty-nine (29) minutes equal one (1) unit;
2. Thirty (30) to forty-four (44) minutes equal two (2) units;
3. Forty-five (45) to fifty-nine (59) minutes equal three (3) units; and
4. Sixty (60) to seventy-four (74) minutes equal four (4) units.

(b) 1. For service coordination services, units shall be determined using the beginning and ending time for a service documented in staff notes in accordance with 911 KAR 2:130, Section 2(9)(g)1. That shall be computed as follows:
2. One (1) to twenty-two (22) minutes equal one (1) unit;
3. Twenty-three (23) to thirty-seven (37) minutes equal two (2) units;
4. Thirty-eight (38) to fifty-two (52) minutes equal three (3) units; and
5. Fifty-three (53) to sixty-seven (67) minutes equal four (4) units;
6. Service coordination minutes spent over the course of a day on a child or family shall be accumulated at the end of the day in order to determine the number of units used.

(4) A payment for a primary or intensive evaluation listed in subsection (2) of this section shall be based on a complete evaluation as a single unit of service.

(5) (a) Except for an augmentative hearing device which is anticipated to cost in excess of $500, a payment for an assistive technology device, including ear molds, replacement wiring, batteries, etc. shall be based on the actual invoiced cost, including the cost of shipping and handling, for the authorized equipment included in the individualized family service plan.

(b) If a child is determined to need an augmentative hearing device that is anticipated to cost in excess of $500, such as a hearing aid, the family shall be referred to the CCSHCN office serving the family's county of residence. The First Steps Program shall not provide payment for an FM system.

(6) Payment for transportation shall be the lesser of the billed charge or:

(a) For a commercial transportation carrier:
1. An amount derived by multiplying one (1) dollar by the actual number of loaded miles using the most direct route; or
2. The metered amount plus an administration charge not to exceed twelve (12) percent of metered amount.

(b) For a private automobile carrier, an amount equal to twenty-five (25) cents per loaded mile

transported;

(c) For a noncommercial group carrier, an amount equal to fifty (50) cents per eligible child per mile transported.

(7) A payment for a group intervention service shall be thirty-two (32) dollars per child per hour of direct contact service for each child in the group with a limit of three (3) eligible children per professional or paraprofessional who can practice without direct supervision.

Section 3. Limitations.

(1) For primary service coordination, payment shall be limited to no more than fifteen (15) hours (or sixty (60) units) per child per six (6) month period unless preauthorized by the CCSHCN. If submitting a prior authorization request to the CCSHCN, the request shall be sent to Payment Authorization Coordinator, CCSHCN, 982 Eastern Parkway, Louisville, Kentucky 40217, and shall include:

(a) The number of additional fifteen (15) minute units requested;

(b) A copy of the current IFSP;

(c) A detailed description of how and when the additional units are to be used; and

(d) A plan for how primary service coordination will be provided in an effective and efficient manner that will prevent the future need for additional units beyond the limit of sixty (60) units of service per six (6) month period.

(2) For initial service coordination, payment shall be limited to no more than twenty-five (25) hours (or 100 units) per child per period of eligibility unless preauthorized by the CCSHCN.

(3) For service assessment:

(a) Payment shall be limited to no more than two and one-half (2 1/2) hours per child per discipline per assessment unless preauthorized by the CCSHCN.

(b) Payment shall be limited to three (3) assessments per discipline per child from birth to the age of three (3) unless preauthorized by the CCSHCN.

(c) A service assessment payment shall not be made for the provision of routine therapeutic intervention services by a discipline in the general practice of that discipline. Payment for a unit of service assessment shall be restricted to the needs for additional testing or other activity by the discipline that go beyond routine practice. Routine activity of assessing outcomes shall be billed as therapeutic intervention.

(4) For therapeutic intervention, unless prior authorized by the CCSHCN in accordance with Section 4 of this administrative regulation, limitations for payment of services shall be as follows:

(a) For office and center:

1. Payment shall be limited to no more than one (1) combined hour of service per week per child per discipline by a:
   a. Professional meeting the qualifications in 911 KAR 2:150; or
   b. Paraprofessional meeting the qualifications in 911 KAR 2:150.
2. Payment shall be limited to no more than one (1) office visit per child, per day, per discipline except that billing for a collateral service while participating in an IFSP meeting or an ARC meeting in the same day shall be allowed.

(b) For home and community sites:

1. Payment shall be limited to no more than one (1) combined hour of service per week per child per discipline by a:
   a. Professional meeting the qualifications in 911 KAR 2:150; or
   b. Paraprofessional meeting the qualifications in 911 KAR 2:150.
2. Payment shall be limited to no more than three (3) disciplines per child per day except that billing for collateral while participating in an IFSP meeting or an ARC meeting in the same day shall be allowed.

(c) For group:

1. In a group setting the service time for each professional or discipline and paraprofessional may extend to the time period of the group, not to exceed two and one-half (2 1/2) hours per day, five (5) hours per week.
2. The ratio of staff to children in group therapeutic intervention shall be limited to a maximum of three (3) children per professional and paraprofessional per group.

(d) Payment for a service shall be limited to a service that is authorized by the entire IFSP team, in accordance with 911 KAR 2:130, Section 2(6) or (7).

(5) For respite, payment shall:

(a) Be limited to no more than eight (8) hours of respite per month, per eligible child;
(b) Not be allowed to accumulate beyond each month; and
(c) Be limited to families in crisis, or strong potential for crisis without the provision of respite.

(6) For collateral services, payment for:
(a) Attendance at one (1) ARC meeting held prior to a child's third birthday shall be limited to the service coordinator and two (2) professionals or paraprofessionals selected by the IFSP team; and
(b) Participation at an initial IFSP meeting by a primary level evaluator shall be limited to an evaluator who has provided feedback and interpretation of the evaluation to the family prior to the IFSP meeting in accordance with 911 KAR 2:120, Section 1(4)(d)2b. Payment shall be at the collateral services rate for the discipline that the evaluator represents.

(7) For cotreatment, payment shall be limited to three (3) disciplines providing services concurrently.

(8) Unless prior authorized by the CCSHCN due to a shortage of primary level evaluators:
(a) A primary level evaluator shall not be eligible to provide therapeutic intervention to a child whom he evaluated and which resulted in the child becoming eligible.
(b) A child's annual evaluation shall be provided by a primary level evaluator who is not currently providing therapeutic intervention to that child.

Section 4. Prior Authorization Process.

(1) Requests for payment for services beyond the limits established in Section 3 of this administrative regulation shall be submitted to the Payment Authorization Coordinator, CCSHCN, 982 Eastern Parkway, Louisville, Kentucky 40217 prior to the service being delivered and shall include the following:
(a) A cover letter describing:
1. Outcomes related to the request;
2. Disciplines involved;
3. Amount of time requested;
4. A description of how long the additional time is needed in order to meet the outcomes on the IFSP; and
5. A description of how the additional time will be incorporated into the child's natural environment and how skills shall be transferred to the parents, caregivers, and other members of the IFSP team;
(b) The medical component of the primary level evaluation in accordance with 911 KAR 2:120, Section 1(4)(d)1, which shall include the following:
1. History;
2. Physical exam;
3. Hearing screening;
4. Vision screening;
5. Other available reports from medical specialists;
(c) Developmental evaluation reports in accordance with 911 KAR 2:120, Section 1(4)(d)2, which shall include the following:
1. Primary level evaluation report; and
2. Intensive level evaluation report, if applicable;
(d) IFSP team member reports completed within the last twelve (12) months by the disciplines involved, including:
1. Assessments; and
2. Six (6) month progress reports;
(e) IFSP documents from the last twelve (12) months, including amendments;
(f) Payor of Last Resort Form, along with available supporting documentation, including:
1. Requests submitted to other payors; and
2. Responses from payor sources;
(g) Transfer of Skills Form; and
(h) Service Planning Activity Matrix Form.

(2) If the authorization panel is not in agreement regarding payment of service time beyond the one (1) hour per week:
(a) The child's IFSP team shall be asked to reconvene for a meeting;
(b) A member of the panel shall participate in the meeting to clearly convey the concerns of the panel; and
(c) If the IFSP team concludes that the services are still needed, payment for the service shall be

authorized for the duration of the current IFSP.

Section 5. Sliding Fee.

(1) Families are required to participate in the payment of services based on a sliding fee scale, except that no charge shall be made for the following functions:
(a) Child find;
(b) Evaluation and assessment;
(c) Service coordination; and
(d) Administrative and coordinative activities including development, review, and evaluation of individualized family service plans, and the implementation of procedural safeguards.
(2) Payment of fees shall be for the purpose of:
(a) Maximizing available sources of funding for early intervention services; and
(b) Giving families an opportunity to assist with the cost of services where there is a means to do so, in a family share approach.
(3) The family share payment shall:
(a) Be explained to the family by the service coordinator;
(b) Be an income-based monthly fee, and with the exception established in paragraph (d) of this subsection, shall begin in the month of the IFSP, at the time therapeutic services are authorized, and continuing for the duration of participation in early intervention services, as determined by:
1. Level of family gross income identified on last Federal Internal Revenue Service statement, as reported by the family.
2. Level of income matched with level of poverty, utilizing the federal poverty measure, poverty guidelines as published annually by the Federal Department of Health and Human Services, based on the following scale:
a. Below 200 percent of poverty there shall be no payment;
b. From 200 percent of poverty to 299 percent the payment shall be twenty (20) dollars per month of participation;
c. From 300 percent of poverty to 399 percent the payment shall be thirty (30) dollars per month of participation;
d. From 400 percent of poverty to 499 percent the payment shall be forty (40) dollars per month of participation;
e. From 500 percent of poverty to 599 percent the payment shall be fifty (50) dollars per month of participation;
f. From 600 percent of poverty and over the payment shall be $100 per month of participation.
(c) Not apply to a child receiving Medicaid or Kentucky Children's Health Insurance Program (KCHIP) benefits;
(d) Not apply to a family who receives only evaluation, assessment, service coordination services or IFSP development in the initial calendar month of eligibility. The initial service coordinator shall notify the CCSHCN First Steps financial case manager immediately if the initial IFSP date is different than the month that therapeutic intervention services are started;
(e) Not apply to a family that does not receive services except those described in paragraph (d) of this subsection for at least one month if prior authorized by the CCSHCN First Steps financial case manager in accordance with paragraph (f)1 and 2 of this subsection. A request shall not be submitted for a retroactive period unless an extenuating circumstance occurs such as an unexpected hospitalization;[.]
(f) Not apply to a family that receives evaluation, assessment, service coordination, or IFSP development because the developmental evaluation or assessment did not reveal a developmental delay. The service coordinator shall notify the CCSHCN financial case manager immediately if this situation exists so that the family is not assessed a family share cost; or
(g) Not prevent a child from receiving services if the family shows to the satisfaction of the CCSHCN an inability to pay, in accordance with the following:
1. The service coordinator shall submit to the CCSHCN First Steps financial case manager, on behalf of the family, a waiver request to have the amount of the family share payment reduced or eliminated for a period not to exceed three (3) calendar months. A request shall not be submitted for a retroactive period unless extenuating circumstances, such as

an unexpected hospitalization, occurs. A family that has a waiver in place as of January 1, 2003 shall have the waiver reviewed at the next IFSP meeting for compliance with this section.

2. The family shall undergo a financial review by the CCSHCN that may:

a. Adjust the gross household income by subtracting extraordinary medical costs, equipment costs, exceptional child care costs, and other costs of care associated with the child's other family members' disabilities; and

b. Result in a calculation of a new family-share payment amount based on the family's adjusted income compared to the percentage of the poverty level established in paragraph (b)2 of this subsection. If a recalculation is completed, the CCSHCN shall conduct a review at least quarterly; or

c. Suspend or reduced the family-share payment, based on a verified financial crisis that would be exacerbated by their obligated family share payment. The CCSHCN shall conduct a review at least quarterly.

(d) Except for a family that refuses to apply for Medicaid in accordance with subsection (6) of this Section, the family share shall not apply to a family who chooses to use their private insurance if the amount of the insurance monies received and applied to the family's services in the calendar year is equal to or greater than the sum of the obligated amount of family share during the same calendar year. Refunding of family share collected in excess of the private insurance reimbursement shall occur after the end of a calendar year.

(4) Income and insurance coverage shall be verified at six (6) month intervals, and more often if changes in household income shall result in a change in the amount of the obligated family share payment.

(5) A family that refuses to have its income verified shall be assessed a family share payment of $100 dollars per month of participation.

(6) Unless there is a religious reason for not applying for Medicaid or KCHIP, a family that is potentially eligible for and refuses to apply for Medicaid or KCHIP shall be assessed a family share payment of $100 dollars per month of participation. A review of a child's potential Medicaid eligibility shall occur at the first face-to-face contact a service coordinator has with the child's parent after January 1, 2003 and every six (6) months thereafter.

(7) If multiple children in a family receive early intervention services, the family share payment shall be the same as if there were one (1) child receiving services.

(8) If a family has the ability to pay the family share but refuses to do so for three (3) consecutive months, the family shall receive service coordination and assessment services only until discharged from the program or the family share balance is paid in full, whichever occurs first.

(9) A family who chooses to use private insurance for payment of a First Steps service shall not be responsible for payment of insurance deductibles or copayments related to this service. First Steps shall assume payment of First Steps-related coinsurance and deductibles.

(10) (a) A provider enrolled in the Medicaid Program shall bill a third party insurance, if any, and Medicaid directly for a service covered through the Medicaid Program prior to billing First Steps. Documentation regarding the billing and payment, if any, shall be maintained in the child's record.

(b) The CCSHCN shall pursue third-party payments for a service rendered to a Medicaid eligible child by a provider not enrolled in the Medicaid Program pursuant to 907 KAR 1:011, Section 10 and 907 KAR 1:005.

Section 6. Incorporated by Reference.

(1) The following material is incorporated by reference:

(a) Payor of Last Resort Form, December 2002;

(b) Transfer of Skills Form, December 2002; and

(c) Service Planning Activity Matrix Form, December 2002.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Commission for Children with Special Health Care Needs, 982 Easter Parkway, Louisville, Kentucky 40217, Monday through Friday, 8 a.m. to 4:30 p.m.

Section 7. The provisions of this administrative regulation shall be effective with services submitted for payment on or after October 1, 2003.